| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | F 272<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected:<br><br>Resident #164 is no longer a resident of the facility, however, a Minimum Data Set (MDS) significant correction was completed 3/12/13 and submitted 3/19/13.<br><br>2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.<br><br>All current residents with weight loss have the potential to be affected. By 4/5/13, MDS nurses (LPNs) audited the most recent MDS assessments to ensure they reflected residents' accurate weights.<br><br>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?<br><br>Weekly, for the next three months, the MDS nurses (LPNs) or the Director of Nutrition Services will audit section K of the MDS and the Weight Record to ensure the MDS assessment reflects the accurate weight. | 3/19/2013<br><br>4/5/2013<br><br>4/5/2013 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 3/28/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 272 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to accurately assess one resident's (#164) weight loss of thirty-five residents sampled.<br><br>The findings included:<br><br>Resident #164 was admitted to the facility on October 15, 2012, with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension, and Compression Fracture of Lumbar Spine.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated January 9, 2013, revealed the resident was cognitively intact, required supervision with set-up assistance for eating, weight was 168 pounds, and had no weight loss or gain.<br><br>Review of the medical record of the Initial Data Collection Tool/Nursing Services dated October 15, 2012, and the Nutritional Data Collection Tool signed and dated October 17, 2012, by the Registered Dietitian, revealed the weight on admission was 180 pounds.<br><br>Review of the Weight Record revealed the weight on January 6, 2013, was 153 pounds, a twenty-seven pound loss since admission or fifteen percent loss.<br><br>Interview with the Registered Dietitian (RD) on | F 272 | 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.<br><br>The Director of Nutrition Services or designee will review the MDS and Weight Record audit and will report findings monthly times three months to the members of the Performance Improvement Committee. The committee will review the findings and make recommendations if any areas are found to be deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. | 4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 272 | Continued From page 2<br>March 11, 2013, at 3:12 p.m., in the activity room, revealed the RD was responsible for the MDS weight data. Further interview confirmed the Quarterly MDS dated January 9, 2013, did not reflect the accurate weight of 153 pounds and failed to identify the weight loss. | F 272 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to care plan a weight loss for one (#65) resident of thirty-five residents sampled. | F 279 | F 279<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected:<br>The Care Plan for Resident #65 was updated on 3/13/13 by an MDS nurse (LPN) to reflect weight loss.<br><br>2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.<br><br>All current residents with weight loss have the potential to be affected. On 3/15/13, the Weight Record for all residents was audited by an RN for potential weight loss. By 4/5/13, MDS nurses (LPNs) audited current care plans to ensure they addressed weight loss as needed.<br><br>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?<br>Weekly, for the next three months, the Director of Nutrition Services, Registered Dietician, Wound Nurse, Restorative Nurse or designees will audit Care Plans for residents identified to have weight loss. | 3/13/2013<br><br>4/5/2013<br><br>4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 279 | Continued From page 3<br>The findings included:<br><br>Resident #65 was admitted to the facility on February 7, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Cerebrovascular Disease, Alzheimer's Disease, Anxiety, History Falls, Hypertension, Spinal Stenosis and History of Prostate Cancer.<br><br>Review of the Admission Minimum Data Set (MDS) dated February 14, 2013, revealed the resident had impaired long and short term memory, required supervision and set-up help for eating, and was 163 pounds with no weight loss or gain.<br><br>Review of the Admission/Readmission Weight Flow Sheet dated February 7 and 8, 2013, revealed 163 pounds (#). Further review revealed on February 9, 2013, a weight of 164#.<br><br>Review of the Weight Record revealed the following weights:<br><br>February 8, 2013, 163#.<br><br>February 10, 2013, 164#.<br><br>February 17, 2013, 149#. (A loss of fourteen # or 8.6 percent (%) in 10 days of admission.<br><br>February 24, 2013, 144#. (A loss of nineteen # or 11.7% in 17 days of admission).<br><br>March 3, 2013, 142#. (A loss of twenty-one # or 12.9% since admission on February 7, 2013).<br><br>Medical record review of the Nutritional Data | F 279 | 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.<br><br>The Director of Nutrition Services or designee will review the Care Plan audit and will report findings monthly times three months to the members of the Performance Improvement Committee. The committee will review the findings and make recommendations if any areas are found to be deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. | 4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 279 | Continued From page 4<br>Collection/Assessment signed and dated February 8, 2013, by the Registered Dietitian (RD) revealed "...weight 163#...Usual Body Weight 160-170#...Ideal Body Weight 154+/-10%...Body Mass Index (identifies possible weight problems) of 25 (indicated overweight for height).<br><br>Medical record review revealed the resident was being provided Speech Therapy for Dysphagia (swallow problems).<br><br>Observation of the resident in the resident's room on March 12, 2013, at 8:00 a.m., and March 13, 2013, at 12:32 p.m., revealed the resident self feeding the meal. Further observation revealed one four ounce shake and two four ounce containers of ice cream on the tray which were consumed along with bites of various food items.<br><br>Medical record review of the care plan dated February 7, 2013, revealed the weight loss had not been addressed.<br><br>Interview with the Director of Nursing (DON) on March 12, 2013, at 2:00 p.m., in the DON's office, confirmed the care plan failed to address the weight loss. | F 279 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. | F 312 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 | Continued From page 5<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to provide assistance with bathing as ordered for one resident (#102) of thirty five residents reviewed.<br><br>The findings included:<br><br>Resident #102 was admitted to the facility on February 23, 2013, with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease.<br><br>Medical record review of the Admission Minimum Data Set dated March 2, 2013, revealed the resident did not have problems with memory or cognition, and required extensive assistance of one person for activities of daily living.<br><br>Observation of the resident on March 12, 2013, at 8:34 a.m. revealed the resident unshaven, with matted, oily hair, dry skin on the forearms, soiled hands and fingernails, and disheveled clothing with small food crumbs on the front area of the shirt.<br><br>Interview with the resident on March 12, 2013, at 8:34 a.m., in the resident's room revealed the resident was alert and oriented. Continued interview revealed the resident reported the facility had failed to shower the resident as the resident had requested and scheduled on March 11, 2013. Continued interview revealed on March 11, 2013, in the morning, the resident requested a shower and a staff member whom was named during the interview informed the resident a | F 312 | F 312<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected:<br>Resident was given a shower on 3/12/13.<br><br>2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.<br>All current residents have the potential to be effected. Education provided to nursing staff 4/5/13 by Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing and designees on providing assistance with bathing as ordered.<br><br>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?<br><br>The Director of Nursing, Assistant Director of Nursing and designees will audit weekly for three months assistance with bathing by comparing the residents' daily shower schedule to the shower skin assessments for each shift to ensure that bathing assistance was provided as ordered. | 3/12/2013<br><br>4/5/2013<br><br>4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 | Continued From page 6<br>shower would be provided during the afternoon. Continued interview with the resident revealed the resident stated "...now it's been nearly five days since I have been in a shower..." Continued interview revealed the resident stated the facility did not provide a bed bath on March 11, 2013, and stated "... if they did I sure don't remember it..."<br><br>Medical record review of the Care Plan dated February 23, 2013, revealed the resident was to be showered twice weekly and as needed.<br><br>Record review of the Seven Day Look Back Report Bath revealed the resident was last showered on March 8, 2013, (four days prior) and the resident was provided a bed bath on March 11, 2013.<br><br>Interview with Licensed Practical Nurse (LPN) #2, on March 12, 2013, at 8:54 a.m., in the east nursing station, confirmed the resident was scheduled for a shower on March 11, 2013, and the facility had documented a bed bath was provided. Continued interview confirmed the resident was alert and oriented, and "...if the resident stated it did not occur I assume it did not occur..." | F 312 | 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.<br><br>The Director of Nursing or designee will review the shower schedule and shower skin assessment audit and will report findings monthly times three months to the members of the Performance Improvement Committee. The committee will review the findings and make recommendations if any areas are found to be deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. | 4/5/2013 |
| F 334 SS=E | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; | F 334 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 334 | Continued From page 7<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal | F 334 | F 334<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected:<br><br>Pneumonia vaccine education was provided and documented by the Health Information Management Director (LPN), Admissions Director (LPN) or designee for residents #53; #127; #25; #95; #35.<br><br>2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.<br><br>By 4/5/13, the Health Information Management Director and Admissions Director completed an audit of pneumonia vaccine consents and documented education provided to residents or responsible parties.<br><br>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?<br><br>The Executive Director provided written education 3/11/13 with the new Director of Admissions regarding completing the pneumonia vaccine consents upon admission. The Director of Admissions will conduct an audit of all admissions for three months to ensure that the documentation for pneumonia vaccine education and acceptance or declination has been obtained. | 4/5/2013<br><br>4/5/2013<br><br>4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 334 | Continued From page 8<br>representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy, and interview, the facility failed to document the resident was offered, provided education regarding the benefits and potential side effects, and received or did not receive the pneumococcal immunization for five residents (#53, #127, #25, #95, #35) of five residents reviewed.<br><br>The findings included:<br><br>Medical record review of the Informed Consent for Pneumococcal Vaccine revealed no documentation regarding residents #53, #127, #25, #95,#35 were offered, provided education regarding the benefits and potential side effects, and received or did not receive the pneumococcal immunization. | F 334 | 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.<br><br>The Director of Admissions or designee will review the pneumonia documentation audit and will report findings monthly times three months to the members of the Performance Improvement Committee. The committee will review the findings and make recommendations if any areas are found to be deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. | 4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 334 | Continued From page 9<br>Review of facility policy, Influenza Vaccine, Pneumococcal Vaccine, and Flu Outbreak Management, dated December 6, 2007, revealed "On admission...the pneumococcal vaccine is offered if the resident has not received it or...status is unknown...Education provided...regarding benefits and side effects or risks...Education, assessment findings, administration, and monitoring are documented..."<br><br>Interview with the Administrator on March 12, 2013, at 7:25 a.m., in the Activity office, confirmed the facility failed to follow the policy and failed to document the administration or lack of administration of the pneumococcal vaccine. | F 334 | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to | F 356 | F 356<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected:<br>Nurse staffing board posted in the main corridor was updated 3/10/13 to reflect current nursing data.<br><br>2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.<br>All resident have the potential to be affected. On 3/28/13 the Director of Nursing educated nursing leadership to update the board daily and assign a licensed nurse to update the board on the weekends. | 3/10/2013<br><br>4/1/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 356 | Continued From page 10<br>residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to post nurse staffing data in a prominent place readily accessible to residents and visitors on a daily basis.<br><br>The findings included:<br><br>Observation on March 10, 2013, at 8:45 a.m., in the front hall off the lobby, revealed the posted nurse staffing data was dated March 8, 2013.<br><br>Interview with Licensed Practical Nurse #1 on March 10, 2013, at 8:50 a.m., in the front hall off the lobby, confirmed the posted nurse staffing data was dated March 8, 2013, and was not current. | F 356 | 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?<br>The receptionist will conduct a daily audit for three months of the nurse staffing board to ensure current data.<br><br>4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.<br><br>The Director of Nursing or designee will review the daily staffing board audit and will report findings monthly times three months to the members of the Performance Improvement Committee. The committee will review the findings and make recommendations if any areas are found to be deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. | 4/1/2013<br><br>4/1/2013 |
| F 514<br>SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and | F 514 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 11<br>systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.<br><br>The findings included:<br><br>Resident #102 was admitted to the facility on February 23, 2013, with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease.<br><br>Medical record review of the Admission Minimum Data Set dated March 2, 2013, revealed the resident did not have problems with memory or cognition, and required extensive assistance of one person for activities of daily living.<br><br>Observation of the resident on March 12, 2013, at 8:34 a.m., revealed the resident unshaven, with matted, oily hair, dry skin on the forearms, soiled hands and fingernails, and disheveled clothing with small food crumbs on the front area of the shirt. | F 514 | F 514<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected:<br>Resident was provided personal care 3/12/13 and it was documented appropriately by a certified nurse aide.<br><br>2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.<br><br>All current residents have the potential to be affected. Education provided by 4/5/13 to nursing staff (registered nurses, licensed nurses, and certified nurse aides) by Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurately documenting personal care provided.<br><br>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?<br><br>The Director of Nursing, Assistant Director of Nursing, MDS nurses (LPNs) or designees will audit the ADL documentation and compare it with shower skin assessments for residents with a state required Minimum Data Set assessment due during the next three months. Any discrepancies will be addressed via a one-on-one education with the associate responsible. | 3/12/2013<br><br>4/5/2013<br><br>4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 12<br>Interview with the resident on March 12, 2013, at 8:34 a.m., in the resident's room revealed the resident was alert and oriented. Continued interview revealed the resident reported the facility had failed to shower the resident as requested and scheduled on March 11, 2013. Continued interview revealed on March 11, 2013, in the morning, the resident requested a shower, and a staff member whom was named during the interview informed the resident a shower would be provided during the afternoon. During continued interview, the resident stated "...now it's been nearly five days since I have been in a shower..." Continued interview revealed, the resident stated the facility did not provide a bed bath on March 11, 2013, and stated "... if they did I sure don't remember it..."<br><br>Medical record review of the Care Plan dated February 23, 2013, revealed the resident was to be showered twice weekly and as needed.<br><br>Record review of the Seven Day Look Back Report Bath revealed the resident was last showered on March 8, 2013, (four days prior) and the resident was provided a bed bath on March 11, 2013.<br><br>Interview with Licensed Practical Nurse (LPN) #2, on March 12, 2013, at 8:54 a.m., in the east nursing station, confirmed the resident was scheduled for a shower on March 11, 2013 and the facility had documented a bed bath was provided. Continued interview confirmed the resident was alert and oriented, and "...if the resident stated it did not occur I assume it did not occur..." | F 514 | 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.<br><br>The Director of Nursing or designee will review the ADL documentation and MDS audit and will report findings monthly times three months to the members of the Performance Improvement Committee. The committee will review the findings and make recommendations if any areas are found to be deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. | 4/5/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445167 | A. BUILDING _____ B. WING _____ | 03/12/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF CROSSVILLE | 80 JUSTICE ST CROSSVILLE, TN 38555 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 13<br>Interview with LPN #3 ( the nurse supervisor on duty on March 11, 2013) by telephone, on March 12, 2013 at 10:00 a.m., revealed on March 11, 2013, "...at approximately 4 p.m. and 8 p.m., the resident declined a shower..." Continued interview confirmed the facility had documented a bed bath had been provided and the facility documentation was not accurate regarding bathing, based on the resident's statements and appearence. | F 514 | | |